Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

320 West Fourth Street, Suite 880
Los Angeles, CA 90013
213-576-7612 voice
213-576-7186 fax
jnozaki@dmhc.ca.gov e-mail

IN REPLY REFER TO
FILE NO: 933 0298
**USPS Priority Mail**

February 4, 2004

# FINAL REPORT

Susan Phyllis Urbanski, Chairman, Board of Directors
**CIGNA BEHAVIORAL HEALTH OF CALIFORNIA, INC.**
450 North Brand Boulevard, Suite 500
Glendale, CA 91203

**ROUTINE EXAMINATION OF CIGNA BEHAVIORAL HEALTH OF CALIFORNIA, INC.**

Dear Ms. Urbanski:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of CIGNA Behavioral Health of California, Inc. (the "Plan") for the quarter ended June 30, 2003, conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on November 21, 2003. The Department accepted the Plan's response electronically on January 14, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's January 14, 2004 response, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies (hardcopy and electronically) of those portions of the Plan's

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its January 12, 2004 response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's response of January 14, 2004 did not fully resolve some of the deficiencies raised in the Preliminary Report issued by the Department on November 21, 2003. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained in the attached revised Final Report, within thirty (30) days after receipt of the report.

Please send a hardcopy of your response directly to the undersigned. In addition, please file the Plan's response electronically, just as you do for regular licensing filings via the Department's web portal (<https://wp.dmhc.ca.gov/efile>) under **Report/Other**, subfolder RUXAM and barcode RX004. Do not file an Execution Page or Exhibit E-1 (Summary of Filing). Please note this process is separate from the electronic financial reporting and is specifically for the response to this final report only. Questions or problems related to the electronic transmission of the response should be directed to Angie Rodriguez at (916) 324-9048 or email at arodriguez@dmhc.ca.gov or Ed Cheever at (916) 324-8738 or email at echeever@dmhc.ca.gov. You may also email inquiries to helpfile@dmhc.ca.gov.

**The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter**

If there are any questions regarding this report, please contact me.

Sincerely,

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

***cc:*** Mark Wright, Chief, Division of Financial Oversight
Lew Chartrand, Acting Assistant Deputy Director, Office of Enforcement
Marie Beckman, Supervising HCSPA
Roslyn R. Mack, Counsel, Division of Licensing
Barbara Yaklin, Monitoring Examiner
Maria E. Marquez, Examiner

# DEPARTMENT OF MANAGED HEALTH CARE

# REPORT OF ROUTINE EXAMINATION

# CIGNA BEHAVIORAL HEALTH OF CALIFORNIA, INC.

**FILE NUMBER: 933 0298**

**DATE OF FINAL REPORT: FEBRUARY 4, 2004**

**SUPERVISING EXAMINER: JANET NOZAKI**

**EXAMINER-IN-CHARGE: MARIA MARQUEZ**

**FINANCIAL EXAMINER: THOMAS ROEDL**

**BACKGROUND INFORMATION FOR**
**CIGNA BEHAVIORAL HEALTH OF CALIFORNIA, INC.**

| | |
|---|---|
| Date Plan Licensed: | August 1, 1990. |
| Organizational Structure: | The Plan is wholly owned subsidiary of Cigna Behavioral Health Inc. (Parent), formerly MCC Companies, Inc., a wholly owned subsidiary of Cigna Corporation (Grandparent). The Plan's former name was MCC Managed Behavioral Care of California, Inc. |
| Type of Plan: | The Plan is a for-profit California corporation organized as a specialized health care service plan. The Plan provides and arranges for mental health care and chemical dependency services. The Plan provides inpatient and outpatient services. It also provides employee assistance programs ("EAP"). |
| Provider Network: | The Plan's contracted providers and hospitals are reimbursed on a reduced fee-for-service basis. |
| Plan Enrollment: | 444,995 as of June 30, 2003 |
| Service Area: | State of California |
| Date of Last Public Report of a Routine Examination: | September 8, 1999 |

FINAL REPORT OF A ROUTINE EXAMINATION OF CIGNA BEHAVIORAL HEALTH OF CALIFORNIA, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of CIGNA Behavioral Health of California, Inc. (the "Plan") for the quarter ended June 30, 2003 conducted by the Department of Managed Health Care (the "Department"), pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on November 21, 2003. The Department accepted the Plan's response electronically on January 14, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's November 21, 2003 response to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited examination of the financial report filed with the Department for the quarter ended June 30, 2003, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:



Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contain in this report, within thirty (30) days of receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

**SECTION I. FINANCIAL REPORT**

**A. BALANCE SHEET – AS OF JUNE 30, 2003**

| | Reported per F/S @ 6/30/03 | Examination Adjustments Debit | Credit | Examination Balance @ 6/30/03 |
|---|---|---|---|---|
| CURRENT ASSETS | | | | |
| Cash | $ 5,842,255 | | | $ 5,842,255 |
| Short-Term Investments | 5,164,416 | | | 5,164,416 |
| Unsecured Affiliate Receivables-Current | 9,405 | | | 9,405 |
| TOTAL CURRENT ASSETS | $11,016,076 | | | $11,016,076 |
| OTHER ASSETS | | | | |
| Restricted Assets | 50,000 | | | 50,000 |
| TOTAL OTHER ASSETS | $ 50,000 | | | $ 50,000 |
| PROPERTY AND EQUIPMENT | | | | |
| Furniture and Equipment – Net | 39,776 | | | 39,776 |
| Computer Equipment – Net | 5,381 | | | 5,381 |
| TOTAL PROPERTY AND EQUIPMENT | $ 45,157 | | | $ 45,157 |
| TOTAL ASSETS | $11,111,233 | | | $11,111,233 |

**BALANCE SHEET**
**AS OF JUNE 30, 2003**

| | Reported per F/S @ 6/30/03 | | Examination Adjustments Debit | | Credit | Examination Balance @ 6/30/03 |
|---|---|---|---|---|---|---|
| CURRENT LIABILITIES | | | | | | |
| Accounts Payable | $ 34,884 | | | | | $ 34,884 |
| Claims Payable | 1,878,619 | R1 | 1,024,155 | | | 854,464 |
| Incurred But Not Reported Claims | 239,844 | | | A1& R1 | 1,824,155 | 2,063,999 |
| Loans and Notes Payable - Current | 716,630 | | | | | 716,630 |
| Amount Due To Affiliates - Net | 1,819,255 | | | | | 1,819,255 |
| TOTAL CURRENT LIABILITIES | $ 4,689,232 | | | | | $ 5,489,232 |
| OTHER LIABILITIES | | | | | | |
| Amount Due To Affiliates – Long Term | 75,550 | | | | | 75,550 |
| TOTAL OTHER LIABILITIES | $ 75,550 | | | | | $ 75,550 |
| TOTAL LIABILITIES | $ 4,764,782 | | | | | $ 5,564,782 |
| NET WORTH | | | | | | |
| Common Stock | 1,000 | | | | | 1,000 |
| Paid in Surplus | 750,000 | | | | | 750,000 |
| Retained Earnings/Fund Balance | 5,595,451 | A1 | 800,000 | | | 4,795,451 |
| TOTAL NET WORTH | $ 6,346,451 | | | | | $ 5,546,451 |
| TOTAL LIABILITIES & NET WORTH | $11,111,233 | | $1,824,155 | | $1,824,155 | $11,111,233 |

**B. INCOME STATEMENT**

STATEMENT OF INCOME AND EXPENSES
FOR THE QUARTER ENDING JUNE 30, 2003

| | Reported per F/S @ 6/30/03 | Examination Adjustments Debit | Credit | Examination Balance @ 6/30/03 |
|---|---|---|---|---|
| REVENUES | | | | |
| Premium Revenue | $ 8,426,329 | | | $ 8,426,329 |
| Interest | 45,764 | | | 45,764 |
| Aggregate Write-Ins for Other Revenue | 15,701 | | | 15,701 |
| TOTAL REVENUE | $ 8,487,794 | | | $ 8,487,794 |
| MEDICAL AND HOSPITAL EXPENSES | | | | |
| Inpatient Services – Fee-for-Service/Case Rate | $ 1,348,408 | | | $ 1,348,408 |
| Other Medical Professional Services – Capitated | 675,322 | | | 675,322 |
| Aggregate Write-Ins for Other Medical and Hospital Expenses | 2,408,508 | | | 2,408,508 |
| TOTAL MEDICAL & HOSPITAL | $ 4,432,238 | | | $ 4,432,248 |
| ADMINISTRATION | | | | |
| Compensation | $ 72,865 | | | $ 72,865 |
| Occupancy, Depreciation and Amortization | 277,414 | | | 277,414 |
| TOTAL ADMINISTRATION | $ 350, 279 | | | $ 350,279 |
| TOTAL EXPENSES | $ 4,782,517 | | | $ 4,782,517 |
| INCOME (LOSS) | 3,705,277 | | | 3,705,277 |
| Provision for Taxes | 1,330,166 | | | 1,330,166 |
| NET INCOME (LOSS) | $ 2,375,111 | | | $ 2,375,111 |

## C. EXPLANATION OF EXAMINATION ADJUSTMENTS

| | **Adjusting Journal Entry** | Debit | Credit |
|---|---|---|---|
| A1 | Retained Earnings | $800,000 | |
| | Incurred But Not Reported Claims | | $800,000 |

To increase the claims liability for incurred but not reported claims ("IBNR"). This item is discussed in more detail under Section III, Item C.

The Plan was required to provide written assurance that the above adjusting journal entry was posted to its books and records or provide an explanation regarding its disposition.

*The Plan responded that it believes the Department's proposed journal entry to be excessive. That conclusion is based on the Plan's claim reserve adequacy analysis and the Plan's review of the Department's run-out claim spreadsheet.*

*The Plan stated that a claim reserve adequacy analysis was performed by the Chief Actuary of the Plan's parent company, CIGNA Behavioral Health, Inc. that concluded the Plan was under reserved by $384,000 as of 9/30/2003. Therefore, prior to the close of books for the third quarter, an increase of the claim reserve/IBNR was recorded in the amount of $384,000 and reflected in the Plan's third quarter 2003 financial filing. The Plan believes the $384,000 booked brings its reserve balance to an adequate level.*

*The Plan submitted the following analysis of the Department's claim run-out spreadsheet to support its position that the proposed $800,000 journal entry is excessive.*

- *Three of the four quarters the Department's run out spreadsheet analyzed, 9/30/02, 12/31/02 and 3/31/03 shows small variances between the Department's analysis and the Plan's booked claims accrual. The Plan submits that with the reserve strengthening of $384,000 added to those quarters (i.e. the reserve strengthening booked in September, 2003 by the Plan), the Plan would have been over accrued in two of those quarters and slightly under accrued by an immaterial amount in the third. The Plan believes this demonstrates the Department's $800,000 IBNR accrual is not needed for three of the four quarters tested.*

- *The Department's run-out spreadsheet for quarter ending 6/30/03 shows an unrealistically high, expected claim payout for the month of June. As the table below shows, the Plan's actual average monthly payout varies significantly with the Department's expected claims payout. The Department's methodology predicts a sudden payout jump to $1,611,000 for the month of June 2003. This is an increase of $363,000 over the most recent 6-month actual and a $452,000 increase over the actual average 24 month experience. There is no evidence that supports a sudden increase in payout expectations. This demonstrates further the Department's $800,000 IBNR accrual is excessive.*

| *Date* | | *Average Monthly Payout* | *DMHC's June '03 Payout* | *Difference* |
|---|---|---|---|---|
| *1/1/03-6/30/03* | *6 mo* | *$ 1,248,000* | *$ 1,611,000* | *$ 363,000* |
| *7/1/02-6/30/03* | *12 mo* | *$ 1,237,000* | *$ 1,611,000* | *$ 374,000* |
| *1/1/01-6/30/03* | *18 mo* | *$ 1,210,000* | *$ 1,611,000* | *$ 401,000* |
| *7/1/01-6/30/03* | *24 mo* | *$ 1,159,000* | *$ 1,611,000* | *$ 452,000* |

- *The Plan also looked at the Department's completion factors. The Department's run out methodology suggests development of completion factors at a rate much more slowly than the Plan's actual completion history, as demonstrated in the table below. The more slowly completion factors develop, the higher that payout expectations become. Thus, by using actual completion factors in the Department's model, the Plan determined that there was no under accrual at 6/30/03. Since there is no evidence to support the Department's slower completion factor development, the Plan continues to assert no further reserve strengthening is needed.*

| *Month* | *Plan's Actual Completion Factors* | *DMHC's Projected Completion Factors* |
|---|---|---|
| *June* | *14.14%* | *8.52%* |
| *May* | *62.35%* | *58.73%* |
| *April* | *82.29%* | *78.82%* |
| *March* | *96.21%* | *88.24%* |

*The Plan respectfully asserts that the information presented above demonstrates the IBNR/reserve increase of $384,000 already booked by the Plan is adequate as of 9/30/03. Further reserving up to the $800,000 suggested by the Department is redundant, resulting in reserve releases in ensuing months.*

**The Department is unable to fully evaluate the claim reserve adequacy analysis performed by the Chief Actuary of the Plan's parent company, CIGNA Behavioral Health, Inc. Therefore, the Plan is requested to provide the data to support the analysis performed by the Chief Actuary with its response to this report.**

| | **Reclassifying Journal Entry** | Debit | Credit |
|---|---|---|---|
| R1 | Claims Payable | $1,024,155 | |
| | Incurred But Not Reported Claims | | $1,024,155 |

To reclassify the claims liability for "authorized but not used services" from claims payable to IBNR. This item is discussed in more detail under Section III, Item C.

The Plan was required to provide written assurance that the above reclassifying journal entry was posted to its books and records or provide an explanation regarding its disposition.

*The Plan responded that it has reclassified claims payable to IBNR in accordance with the reclassifying journal entry, R1. Furthermore, beginning with the Plan's 9/30/03 quarterly financial filing, the amount recorded as IBNR was changed to reflect the Department's audit guidance and will continue on future financial filings.*

**The Department finds that the compliance effort by the Plan is responsive to the deficiency cited and the corrective action required.**

## SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

| | |
|---|---|
| Net Worth Per Examination as of June 30, 2003 (From Section I.A) | $ 5,546,451 |
| Less: Receivables from Officers, Directors, and Affiliates | 0 |
| Tangible Net Equity | $ 5,546,451 |
| REQUIRED TNE as of June 30, 2003 | 1,065,203 |
| EXCESS TNE at June 30, 2003 | $ 4,481,248 |

As of June 30, 2003, the Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76.

**No response was required to this Section.**

## SECTION III. COMPLIANCE ISSUES

### A. CLAIMS REIMBURSEMENT

Section 1371 requires a specialized health care service plan to reimburse claims within thirty (30) working days after receipt of the claim, unless the claim is contested or denied by the plan in which case, the claimant shall be notified in writing, that the claim is contested or denied, within 30 days after receipt by the health care service plan.

Our examination disclosed the following:

- There were 42 claims (representing 41% of the 102 claims reviewed) that were paid late during the period June 1, 2001 through June 30, 2003.

- There were 4 claims that were denied more than 30 working days after the receipt date.

According to the Plan's management, the claims system was programmed to identify late claims as those that were over forty-five (45) working days instead of thirty (30) working days. The Plan based the programming of its computer system on its interpretation that the 45 working days requirement of Section 1371 and 1371.35 would apply since many of these claims arise from a contractual arrangement with Cigna HealthCare of California, Inc., a full service health plan.

The Plan was required to provide a detailed description of the policies and procedures implemented to ensure that all uncontested claims are paid within the timeframe required by Section 1371 and 1371.35 for specialized health plans. These policies and procedures were to specifically address the Plan's process for the payment of interest on uncontested claims that are paid late. The Plan's response was to state the date these policies and procedures were implemented, and the management position responsible for ensuring ongoing compliance with Section 1371 and Section 1371.35.

**These claim violations were referred to the Office of Enforcement.**

*The Plan responded that it respectfully disagrees with the Department's determination that the Plan is significantly deficient in the timeliness of its claim payments. The Plan desires the Department to consider the following:*

*The Plan stated that the Department's finding that 41% of the claims sampled were paid late by the Plan creates the false impression that this high percentage of late payments extends to all Plan claims paid during the audit period (June 1, 2001 to June 30, 2003). According to the Plan's review of total claims paid during the audit period, approximately 6% were paid beyond 30 days of receipt. The Plan is in the process of determining the exact percentage of claims paid beyond 45 working days of receipt consistent with its position as set forth below, but it is likely to be 5% or less.*

*The Plan stated that the Department's finding was based upon a sampling methodology that resulted in a disproportionately high number of reprocessed claims. A reprocessed claim is a claim that has been duplicated in the system due to a problem with the claim such as a provider error, Plan error, lack of information, eligibility issue, etc. Duplicating the problematic claim in the claims system allows the Plan to make corrective adjustments without requiring the provider to resubmit the claim. The reprocessed claim is aged from the date originally received and typically requires more than 30 days to process. During the audit period, the Plan stated that approximately 83% of the reprocessed claims required over 30 days to pay. This statistic demonstrates that there is a high likelihood that a reprocessed claim will be paid beyond 30 days from receipt.*

*The Plan has determined that approximately 52% of the claims sampled by the Department (53/102) were reprocessed claims. By contrast, approximately 5% of total claims paid in the audit period were reprocessed claims.*

*The Plan contends that many reprocessed claims were actually processed timely. If the reason for reprocessing the claim was because the provider's initial claim was not complete, the Plan could have rejected the incomplete claim and required the provider to resubmit the entire claim when corrected. Rather than impose this burden on the provider, the Plan delayed processing of the claim, then reprocessed the claim when the problem was corrected. During the audit period, the Plan's systems could not account for the days the claims were legitimately delayed before reprocessing was completed making it appear that the reprocessed claims were simply paid late. If the Plan was able to demonstrate that all reprocessed claims were processed timely, the Plan calculates that approximately only 2% of claims during the audit period were paid beyond 30 days.*

*The Plan responded that the Department's determination of claim violations was also based upon the premise that the Plan had 30 working days ("30-day Standard") from the date of receipt to pay or deny the claims reviewed during the audit period as opposed to 45 working days ("45-day Standard). The Plan submits that until the Department issued its claim settlement regulations (Rule 1300.71) in August, 2003, neither the claims reimbursement statues or the Department's position was clear on whether the 30-day Standard or the 45-day Standard applied to specialized mental health plans.*

*Furthermore, the Plan stated that it filed a new model provider agreement with the Department on July 25, 2000 that included the following provision:*

> *"CIGNA Behavioral Health of California, Inc. will require Payor to make payment to PROVIDER within forty-five (45) working days of the receipt by CIGNA Behavioral Health of California, Inc. or its designee of a properly completed bill for Covered Services."*

*The Plan stated that on August 24, 2000 it received a comment letter from the Department directing the Plan as follows:*

> *"Page 3, Section 4d. states that the Plan will require Payor to make payment to Provider within forty-five working days of the receipt of a properly completed bill. Section 1371 requires the Plan to reimburse claims "as soon as practical," but no later than thirty or forty-five working days. <u>Please revise to clarify that the Plan will require Payor to make payment to Provider as soon as practical, but no later than forty-five working days."</u>*

*The Plan filed the revised provider agreement with the change required by the Department on September 11, 2000. The Plan contends that the Department did not require the Plan to apply the 30-day Standard, but expressly approved the Plan's use of the 45-day Standard.*

*The Plan believes that it is entitled to apply the 45-day Standard to claims processed on behalf of its affiliate, CIGNA HealthCare of California, Inc. ("CIGNA HealthCare") prior to the effective date of the new claims settlement practices regulations.*

*CIGNA HealthCare is a health maintenance organization under Section 1371 and Section 1371.35, and entitled to have the 45-day Standard applied to claims for services rendered under its group contracts. Section 1371 and 1371.35 require CIGNA HealthCare to hold its medical groups, independent practice associations and other contracting entities to this standard when claims processing activities are delegated. The Plan reasonable concluded that, as a contracting entity of CIGNA HealthCare, it was entitled to apply the 45-day Standard to delegated claims.*

*The Plan acknowledges that under the new claims settlement practices regulations (Rule 1300.71), a specialized plan contracting with a full service plan will be held to the 30-day Standard. However, since those regulations were not in effect during the audit period, the Plan should not be penalized for applying the 45-day Standard based upon its reasonable interpretation of Sections 1371 and 1371.35.*

*The Plan responded that it has researched the 42 claims that the Department identified as paid late and determined 22 were paid within the 45-day Standard. Nineteen of those 22 claims meeting the 45-day Standard were paid by the Plan on behalf of CIGNA HealthCare. Thus, the Plan respectfully submits that the audit findings overstate the potential claim violations by nearly half on this issue alone.*

*The Plan stated that its current policy is to auto adjudicate all complete claims received and deny, pend, or manually adjudicate all remaining claims in 30 working days or less. The Plan has seen the percentage of claims processed within 30 working days or less increase steadily over the past several years to reach 98% in 2003.*

*The Plan responded that compliance instructions have been developed specific to California requirements to instruct the claims examiners when interest is due and the appropriate rate of interest.*

*The Plan confirmed that the compliance instructions that are available to claims examiners paying Plan claims reflect that if an uncontested claim is not processed within 30 business days after receipt, interest will accrue at the rate of 15% per year beginning on the first calendar day after the time to process deadline. The instructions also state that if interest is not included with the payment of the late claim, a $10 penalty fee is to be added to the payment. These instructions were originally implemented effective January 1, 2001. The instructions have been updated to reflect the new claim settlement practices regulations that became effective January 1, 2004. The Plan's Chief Financial Officer has the oversight responsibility to ensure ongoing compliance with Sections 1371 and 1371.35.*

**The Plan is requested to provide a copy of the comment letter it received on August 24, 2000 from the Department with its response to this report.**

**The Plan's response has been forwarded to the Office of Enforcement. Presently, the Office of Enforcement is dealing directly with the Plan on this matter.**

## B. PAYMENT OF INTEREST

Section 1371 further states that if an uncontested claim is not reimbursed within the 30 working day period, interest shall accrue at the rate of fifteen percent (15%) per annum beginning with the first calendar day following the 30 working day period. A plan failing to comply with this requirement shall pay the claimant a $10 fee for all claims, including those for emergency services.

Section 1371.35 (b), which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 30 working days after receipt, the plan shall pay the greater of $15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 30 working day period.

The interpretation issue, cited above, resulted in no interest paid for claims that were paid after 30 working days and before 45 working days. It also resulted in the underpayment of interest for claims paid after 45 working days.

Furthermore, our examination disclosed the following:

- After January 1, 2001, the Plan continued to pay an interest rate of 10% per annum. The Plan started paying the correct interest rate of 15% per annum in September 2003.

- The Plan did not automatically pay a $10 fee when interest was paid on late claims.

The Plan was required to submit a Corrective Action Plan ("CAP") that provides for the identification of all claims since the prior examination of March 31, 1998 on which interest should have been paid or was underpaid. This was to include any claims that were first denied in error and later paid.

Furthermore, the Plan was required to submit evidence that the correct amount of interest and $10 fee, if applicable, were paid for all claim identified. If the process was not completed at the time the Plan filed its response, the CAP was to state the timeframe in which the identification and payments would be completed. The Plan was reminded that the interest rate on late claims was ten (10%) percent up to December 31, 2000. Effective January 1, 2001, Section 1371 was amended to increase the interest rate on late claims to fifteen (15%) percent. In addition, the Plan was required to state the management position responsible for continued compliance.

**These claim violations were referred to the Office of Enforcement**.

*The Plan responded that it is in the process of identifying claims where interest was owed but not paid or was underpaid during the time period requested by the*

*Department. Due to the numerous claim records that need to be reviewed, the process may not be completed for several weeks. Upon completion of the process, the Plan will work with the Department to resolve the interest issues.*

*The Plan does not believe the amount of interest owed will be significant or should be viewed by the Department as a material violation. The Plan asserts that a majority of its claims during the audit period were auto adjudicated and were paid well before the 45 working day limit (and well before even the 30 working day limit). An analysis of all claims paid during the audit period has revealed that the average number of days the Plan took to pay claims was 18 calendar days. Thus, on the average, Plan providers received payment of claims in less than half the time allowed by the 45-day Standard (or even the 30-day Standard).*

*Interest is added to late claim payments in order to compensate a provider for the loss of use of money that the provider otherwise would have had if the claim had been paid timely. By is early payment of claims, providers had the use of money that they otherwise would not have had if the Plan had taken the entire 45 working days allowed by law. The Plan submits that the interest a provider may have earned from the early payment of claims compensated the provider for those relatively few claims that were paid late. While the Plan certainly intended to comply with the law on interest payments to the best of its ability, the Plan believes the Department should consider the benefits the provider gained from the early payment of claims in its overall determination of payment of interest deficiencies.*

**The Plan's response has been forwarded to the Office of Enforcement. Presently, the Office of Enforcement is dealing direct with the Plan on this matter.**

## C. INCURRED BUT NOT REPORTED CLAIMS LIABILITY

Rule 1300.77.2 (a) requires plans to calculate the estimate for incurred but not reported claims liability ("IBNR") pursuant to a method held unobjectionable to the Commissioner.

Section 1384 (d) requires that a plan shall make any special reports to the director as the director may from time to time require.

Our examination included a hindsight analysis report (i.e. run-out) of the Plan's claim liability using paid claim data for the period June 1, 2001 through June 30, 2003. This analysis disclosed that the Plan had understated its IBNR liability during each of the preceding four quarters ending June 30, 2003. Furthermore, we estimated that the Plan's IBNR was understated by approximately $800,000 as of June 30, 2003. Therefore, an examination adjustment of $800,000 was required to increase the Plan's IBNR as of June 30, 2003. (See AJE)

In addition, our examination disclosed that the Plan had recorded as claims payable an accrual for services that had been authorized but not yet used. These liabilities should be recorded as part of the Plan's IBNR since these services have not yet been used or reported. Therefore, the reclassification adjustment noted in Section I was required. (See RJE)

The Plan was required to complete and file supporting Schedules G, H and I of the DMHC Financial Report. These schedules were to be filed for each quarterly financial report filed with the Department beginning with the quarter ended September 30, 2003.

*The Plan's response is summarized in Section I.C. to the Department's proposed IBNR adjustments.*

**As stated in Section I.C., the Department is unable to fully evaluate the claim reserve adequacy analysis performed by the Chief Actuary of the Plan's parent company, CIGNA Behavioral Health, Inc. Therefore, the Plan was requested to provide the data to support the analysis performed by the Chief Actuary with its response to this report.**

*The Plan responded that it completed and filed schedules G, H and I of the DMHC Financial Report with its filing of the third quarter report at 9/30/03. The Plan will continue to file schedules G, H, and I with each of its subsequent quarterly financial filings.*

**The Department finds that the compliance effort by the Plan to complete and file supporting schedules is responsive to the deficiencies cited and the corrective actions required .**

## D. MATERIAL MODIFICATIONS AND AMENDMENTS

Section 1352 (a) and (b), and Rules 1300.52 and 1300.52.1 require all plans to file an amendment with the Director within thirty (30) days after any change in the information contained in its application, other than financial and statistical. Material changes to the Plan's operation are required to be filed as a Notice of Material Modification twenty (20) days prior to any changes being implemented as specified in this Section and Rules.

The administrative service agreement filed with the Department in May 1996 between MCC Companies and MCC Managed Behavioral Care of California, Inc. is not consistent with the current practices of the Plan. Our examination disclosed the following practices that were not included in the agreement:

- The employees of Cigna Behavioral Health, Inc. (parent of the Plan) in Eden Prairie, Minnesota perform the entire claims process from receiving the claims to the adjudication process.

- The claims checks are being printed and mailed by a Cigna Corporate facility in Pennsylvania.

- A subcontractor "Outsource Offshore, Inc" is performing the data entry functions. The data entry functions are being performed in Chennai, India.

The Plan was required to file a revised administrative service agreement. The revised agreement was to be updated to include the current services being provided by the Plan's affiliates and include the oversight procedures the Plan performs to monitor continuance compliance with Sections 1351 and Rule 1300.51. The Plan was to indicate the date this monitoring system was implemented and identify the management position responsible for continued compliance.

In addition, the Plan was requested to submit a detailed description of the actions taken to ensure that the claims processing function performed by its parent will comply with the new claim processing standards and requirements under Rule 1300.71 that will become effective January 1, 2004.

The agreement was to be filed electronically as an amendment filing with the Department. The cover page for the filing was to state that it was filed as a result of the recent financial examination.

The Plan was requested to provide evidence (i.e., a copy) in its response to this report that the requested filing had been submitted to the Department within forty-five (45) days after receipt of the preliminary report.

*The Plan's response included a copy of the amendment filing submitted to the Department on December 31, 2003. A description of the Plan's monitoring system and the management position responsible for oversight was also included in the filing.*

**The Department finds that the Plan was responsive to the corrective actions required. However, the review of this amendment filing was performed through the Department's licensing process and a comment letter was issued on February 3, 2004.**

## E. PROVIDER CONTRACT

Rule 1300.67.8 requires written contracts to be executed between the Plan and each provider of health care services. This Rule states that such contract shall be prepared in a manner that permits confidential treatment by the Director of payment rendered or to be rendered to the provider without concealment or misunderstanding of other terms and provision of the contract, as well as other requirements.

Our examination disclosed that the provider contracts selected for review had been amended to pay all claims within 45 working days of the receipt of the claim.

The Plan was required to revise its provider contracts to indicate that all claims will be paid within 30 working days of the receipt of the claim in accordance with Section 1371 and Section 1371.35. The revised provider contract was to be electronically filed as an amendment filing with the Filing Clerk in Sacramento.

The Plan was requested to provide evidence (i.e. a copy) in its response that the above requested item was filed with the Department within forty-five (45) days after receipt of the preliminary

report

In addition, the Plan was required to provide written assurance that it has amend all of its provider contracts so that they are in compliance with the Act or state the time frame it would have completed this process.

The Plan was to state the management position responsible for oversight of continued compliance and the controls implemented for ongoing compliance.

*The Plan's response included a copy of the amendment filing submitted to the Department on January 2, 2004. The Plan identified the Plan counsel as the individual responsible for amending model provider contracts to comply with the Knox-Keene Act and accompanying regulations. The Plan stated that actions have been taken in the past and will continue to be taken in the future to modify model provider contracts to comply with California law.*

**The Department finds that the Plan's corrective action was not fully responsive to the deficiency cited and the corrective actions required. The response did not provide written assurances that the Plan had amend all provider contracts to comply with Section 1371 and 1371.35 or state the time frame it will complete this process.**

**The Plan is again required to provide written assurance to the Department that all contracts have been amended or state the time frame it will complete this process.**

## F. FIDELITY BOND

Sections 1351 (q) and 1376 and Rule 1300.76.3 require each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or blanket position bond written by an insurer licensed by the California Insurance Commissioner.

The fidelity bond provided for review by the Plan during the examination expired on March 30, 2003.

On October 31, 2003, the Plan submitted a certificate of liability insurance that indicated that the policy had been renewed with an expiration date of March 30, 2004. However, the Plan's policy did not include an endorsement or include specific language that the bond covered each officer, director, trustee, partner and employee of the plan, whether or not they are compensated.

The Plan was required to electronically file a copy of its fidelity bond demonstrating compliance with Rule 1300.76.3 with the Filing Clerk in Sacramento. In addition, the Plan was requested to provide evidence (i.e., a copy) in its response that the requested filing has been made within forty-five (45) days after receipt of the preliminary report.

In addition, the Plan was required to provide the written procedures implemented, the date of implementation, and the management position responsible for ensuring continued compliance.

*The Plan's response included a copy of the amendment filing submitted to the Department on January 8, 2004 containing the policy endorsement. The Plan stated that the Chief Financial Officer is responsible for assuring that adequate level of fidelity bond coverage is in place by obtaining new certificates of coverage from insurance carriers at policy renewal dates.*

**The Department finds that the compliance efforts by the Plan is responsive to the deficiency cited and the corrective actions required.**

## G. MALPRACTICE INSURANCE

Section 1351(o) requires each plan to have evidence of adequate insurance coverage or provide self-insurance for claims for damages arising out of the furnishing of health care services.

The policy number on the certificate of insurance for the malpractice policy listing the Plan as a covered insured did not match the policy binder.

The Plan was required to submit a revised certificate of insurance that matches the policy binder with its response to this report.

*The Plan's response included a copy of the Certificate of Liability Insurance and the insurance policy (FB0301651) confirming that the Plan had adequate professional services errors and omissions coverage in effect from March 30, 2003 to March 30, 2004.*

**The Department finds that the compliance effort by the Plan is responsive to the deficiency cited and the corrective action required.**

## IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

**No response is required to this Section.**

Response to Final Routine Financial Exam Report

1049RX004

Susan Urbanski
President/Executive Director

CIGNA Behavioral Health

450 North Brand Boulevard #500
Glendale CA 91203
Telephone 818.551-2717
Facsimile 818.551-2788
Susan.urbanski@cignabehavioral.com

February 13, 2004

**VIA FEDERAL EXPRESS**

Janet Nozaki, CPA
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight
Department of Managed Health Care
320 West Fourth Street, Suite 880
Los Angeles, CA 90013

RE: CIGNA Behavioral Health of California, Inc.
File No. 933-0298
Response to Final Report of Routine Examination
dated February 4, 2004

Dear Ms. Nozaki:

I wish to respond on behalf of CIGNA Behavioral Health of California, Inc. (the "Plan") to the Department's Final Report of Routine Examination dated February 4, 2004.

The Plan is pleased the Department determined that the corrective actions taken by the Plan on several of the deficiencies identified during the survey satisfied the Department's concerns. The Plan is disappointed that the Department believes that additional corrective actions are necessary on other cited deficiencies.

Although the Plan will be responding to the Department's request for additional corrective action under separate cover and within the 30-day timeframe required by the Department, the Plan wishes to briefly summarize the response. Further, the Plan requests that this letter be appended to the Final Report pursuant to Section 1382(d). Since the Department's Final Report accurately restated the Plan's response on the key issues raised in the Preliminary Report, the Plan does not think it is necessary for the Department to append the Plan's response to the Preliminary Report dated and filed January 9, 2004 (accepted on January 14, 2004) to the Department's Final Report.

The Department's Final Report expressed continuing concern over the adequacy of the Plan's claims reserve. Although the Plan continues to disagree with the Department's methodology used to calculate estimated incurred but not reported claims liability (IBNR),

the Plan has decided to resolve the issue by increasing its IBNR by $800,000 in the 4th quarter, 2003 in addition to the increase of $384,000 it made during the 3rd quarter, 2003. Accordingly, the Plan has booked the following additional reserve strengthening amounts:

| | |
|---|---|
| September 2003 | $384,000 |
| November 2003 | 400,000 |
| December 2003 | 400,000 |

Total Strengthening $1,184,000

The actions taken by the Plan exceed the Department's request for reserve strengthening of $800,000 and should fully satisfy the Department's concerns. Therefore, it should no longer be necessary for the Plan to provide the additional data requested by the Department.

The Plan continues to communicate with the Department's Enforcement Division concerning the late payment of claims and interest and is confident it will soon reach a resolution of all issues. The Plan notes that a thorough analysis of all claims paid during the audit period (June 1, 2001 to June 30, 2003) concluded that the Plan paid approximately 96% of all claims within 30 working days of receipt and over 97% within 45 working days of receipt. The Plan respectfully encourages the Department to utilize a claims sampling methodology that would more accurately reflect actual claims payment experience rather than the methodology that resulted in the conclusion that the Plan paid 41% of its claims late.

If the Department is unable to locate its August 24, 2000 letter to the Plan, the Plan is willing to supply the requested letter in its response to the Department's request for additional information. Similarly, the Plan will provide the additional assurances relating to its provider contracts in its response to the Department's request for additional information. Finally, the Plan will be responding to the Department's comment letter relating to its administrative services agreement within the timeframe requested by the Department's licensing counsel.

The Plan believes it has addressed all the concerns raised by the Department in its routine financial examination. The Plan appreciates the courtesy and professionalism demonstrated by the Department staff throughout the audit process.

Should you have any questions concerning this response do not hesitate to contact my office.

Sincerely,

Susan Urbanski

C: Kenneth B. Carter